HEALTH INSURANCE REFUND REQUEST FOR KENTUCKY GOVERNMENT EMPLOYEES

CARRIER: HUMANA **DATE:**

Please issue the following refund for premiums withheld in error:

Last Name, First Name	SSN	Company Number	Refund to Employee	Shortfall Request	Refund to Employer	Refund to KST	Coverage Month
			$	$	$	$	
Reason for Request							
			$	$	$	$	
Reason for Request							
			$	$	$	$	
Reason for Request							
			$	$	$	$	
Reason for Request							
			$	$	$	$	
Reason for Request							
			$	$	$	$	
Reason for Request							
			$	$	$	$	
Reason for Request							

Return above checks to:

Insurance Coordinator: _____
Cabinet: _____
Address: _____

Telephone Number: _____
Fax Number: _____

Last Updated:08/10/2009